

to the

Federal Trade Commission/
Department of Justice Joint Hearing

**RE: Health Care Competition Law
and Policy – Quality and Consumer
Information: Physicians**

Presented by: Nancy H. Nielsen, MD, PhD
Vice Speaker, House of Delegates
American Medical Association

May 30, 2003

Statement
of the
American Medical Association
to the
Federal Trade Commission/Department of Justice Joint Hearing
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**RE: HEALTH CARE COMPETITION LAW AND POLICY—QUALITY
AND CONSUMER INFORMATION: PHYSICIANS**

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Introduction

Good afternoon and thank you. My name is Dr. Nancy H. Nielsen. I am an internist from Buffalo, New York, and the Vice Speaker of the American Medical Association (AMA) House of Delegates. I am also a member of the Board of Directors of the National Patient Safety Foundation (NPSF).

Overview

Physicians recognize it is their moral and ethical responsibility to provide quality health care. To this end, many AMA programs and initiatives are addressing quality improvement:

- The AMA was one of the original sponsors in the early 1990s, with the predecessor to the Agency for Healthcare Research and Quality (AHRQ), and the American Association of Health Plans (AAHP)—of the **The National Guideline Clearinghouse**. The **Clearinghouse** offers an internet-based repository of clinical practice guidelines designed to assist physicians in their clinical decision-making.
- Even many years before the **Clearinghouse**, the AMA, as a Federation of state and national medical specialty societies, had brought the house of medicine together on issues of quality. This included the **Practice Guidelines Partnership** and the **Clinical Quality Improvement Forum**.
- When important gaps between medical knowledge and practice are identified, the AMA and appropriate medical specialty societies have collaborated on such projects as the **Quality Care Alerts**—concise mailings and Web site postings to alert physicians to those gaps or variations in practice.
- Earlier quality initiatives have led to the development of our newest and most vigorous initiative bringing quality closer to patients. The **Physician Consortium for Performance Improvement** is a collaboration of clinical experts from over 60 medical specialty societies, state medical associations, AHRQ, and CMS. Members of the consortium work together to identify and develop clinical measures that will result in improved patient care.

There is a critical difference between guidelines and performance measures. Think of guidelines as a roadmap and performance measures as the most critical markers along the way that are associated with good patient outcomes.

Remember, what presents to the physician is a patient, not an abstraction. Each patient is unique with his or her own risk factors and underlying illnesses. In order to look at outcomes reliably you have to look at the patient and the patient is not an abstraction. Therefore, one has to carefully adjust for risk factors and underlying conditions. We call this “case mix adjusting.” This way you avoid stigmatizing a physician who may be caring for a large number of high risk patients. This is a critical whenever performance measures are going to be utilized to compare groups of physicians or individual physicians. It is vital to remember to adjust case-mix first.

A recent study from Massachusetts, “Physician Clinical Performance Assessment: The State of the Art,” places in perspective the assessment of physician clinical performance. The study concludes that the use of individual performance data for external reporting carries with it numerous analytic challenges. For example, sample size. The number of patients with a particular medical condition who a physician treats in one year may not be large enough to establish a good estimate of that physician’s performance. And, there could be other impediments to good outcomes, such as patients with poor health literacy who have trouble understanding instructions, economic barriers that patients face in complying with drug therapy, or a myriad of other factors.

At this time, it remains statistically difficult to assess individual physician competence or distinguish among physicians on outcomes. Recognizing this, the AMA continues to work on multiple fronts to help all physicians improve outcomes for the patients we serve.

Let's look at volume as an indicator of quality. The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance.

It may seem intuitively obvious that if a physician has a higher volume, there will be better outcomes. But, that has not been definitively established. Indeed, a patient should be free to raise questions about treatment, including volume and quality with his or her physician.

Physicians should answer these questions openly and honestly. However, physicians should also be equally free to discuss the issue completely. Does quantity really equal quality?

Being an informed consumer means being fully informed regarding quantity versus quality and how it relates to their care.

How about geographic variation in medical care? There are numerous articles written about geographic variations in the use of particular treatments or procedures. This occurs more frequently in situations when there is more than one therapeutic option, no accepted standardized treatment for the condition, or when beliefs about the risks and benefits of a particular treatment option vary. In those situations where there is relative agreement on the clinical recommendations or guidelines—for example, hip fracture repair—we see little

geographic variation. The AMA is firmly committed to relying on scientific evidence as we address variations in care.

Finally, with regard to consumer information in the academic setting, patients who receive care at teaching hospitals may indeed be treated by physicians or other health care professionals who are at different levels of training. Physicians in training must be supervised under a structured residency program. The AMA Code of Medical Ethics states that patients should be informed of the identity and training status of individuals involved in their care.

All health care professionals share the responsibility for properly identifying themselves. Students and their supervisors should refrain from using terms that may be confusing or ambiguous when describing their status to patients, and patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients. They should ensure they are willing to permit such participation.

Conclusion

The AMA appreciates the opportunity to highlight to the FTC and Justice Department some of our efforts to advance health care quality. We will continue to provide physician leadership in the development, implementation, and appropriate use of performance measures for physicians to enhance the quality of care for their patients.

Thank you.